



EMPLOYER'S REPORT OF INJURY

CLAIM NUMBER

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Before completing this form, please read notes on the back.
Print in BLOCK LETTERS and mark with a tick where appropriate.

EMPLOYER DETAILS

Full name as per policy _____

Fax No. _____ Telephone No. _____ Policy No. _____

Postal address _____ Post Code _____

Location address (specify number, street, suburb) _____

Name and location where worker employed (depot, branch, etc.) _____

_____ Cost centre No. _____

Business activity or profession _____

Name if Rehabilitation Co-ordinator _____

WORKER'S EMPLOYMENT PARTICULARS

Full name of injured worker (surname) _____ First name _____

Residential address _____ Post Code _____

Sex M or F Date of birth _____ Date employed _____

Full time or Part-time : _____ Employed as Permanent or Casual

Occupation _____ Hours worked per week _____

Main tasks performed by worker _____

Is worker a direct employee YES NO ; if NO explain employment _____

Where time lost please complete questions on rear of form. NB Please complete declaration on the back.

INJURY DETAILS – Where did the injury occur?

During a break at work Vehicle accident while working

At work Away from work during a recess Travelling to or from place of employment

Date of injury _____ Time of injury _____ AM/PM _____ Date notice given _____

Time notice given _____ AM/PM _____ To whom was the accident reported? _____

Address and place where injury occurred _____

Names and address of witnesses (if any) _____

Details of previous related injuries if known _____

How did the injury occur and what was the worker doing at the time? (Eg. Slipped while walking down stairs)

Describe the worker's injury or condition (Eg. Laceration, dermatitis) _____

Which parts of the body were affected? (Eg. Upper left arm, right ankle) _____

GIVE DETAILS OF OTHER CIRCUMSTANCES WHICH WOULD ASSIST THE INSURER TO ASSESS THE CLAIM (Eg. Do you query the validity of the claim? If so, why?)

In my opinion _____

TIME LOST PARTICULARS

Date worker ceased work	Time	Has worker resumed work?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
If YES, date resumed work	Time resumed work	AM/PM		
Normal working hours (Eg. 7.00am to 3.30pm Monday to Thursday: 7.00am to 1pm Friday.)				
	AM/PM to	AM/PM	AM/PM to	AM/PM
Exact time lost:	Days	Shifts	Hours	Award hours worked per week
	Days worked per week	Rostered days off		

AWARD INFORMATION

(a) is the worker employed under (Please tick appropriate box)

Federal Award

State Award

No Award or Agreement Applicable

Registered Industrial Agreement

Registered Enterprise Agreement

(b) Award or Agreement Title _____

(c) Worker's Classification or Number _____

(d) What is the worker's **minimum weekly wage rate**, exactly as prescribed by worker's classification name and number, grade or group in the award or Registered Industrial Agreement mentioned above? **EXCLUDE** shift work, overtime, penalty rates, site allowance, over-Award payments or payments to cover expenses incurred.

Rate per week \$ What is the actual current rate per week paid to worker? \$

Is the worker: An Apprentice Trainee Indentured Apprentice Adult Apprentice

Which year of apprenticeship is the worker in? 1st year 2nd year 3rd year 4th year

If the worker is employed as a **part-time** or **casual** employee, what is the average number of hours worked per week as a casual or part-time employee?

(e) Where there is no Award or Agreement to cover the type of work being performed by the injured worker, please state the **average** weekly earnings of the injured worker during the past 12 months. \$

REHABILITATION

Has worker resumed work under the guidelines of a Rehabilitation Programme YES NO

Has the Worker been referred to a Rehabilitation Provider? YES NO

If YES; Name of Rehabilitation Provider: _____

EMPLOYER DECLARATION

I (print name, position) _____

declare that the details above are true and correct in every particular,

Signature of employer or authorised person _____ Date _____

EMPLOYERS PLEASE NOTE

1. This notice of claim must be forwarded within 7 days of lodgement of claim by worker. This also applies to any documentation received in respect of claim – penalty \$5000.
2. Payment of weekly compensation must commence within 21 days of lodgement of claim unless notice of dispute is lodged within this time period – penalty \$5000.
3. If worker has not resumed work at time of lodgement of this claim, it is important that you notify the Insurer immediately of worker's return to work.
4. No compensation payments are to be made without prior approval of Insurer and only after receipt of a covering medical certificate in the form prescribed under the Act.
5. Weekly benefits will be paid at the minimum award rate to the employer.
6. Payments will be made to the employer unless special arrangements are made.

OFFICE USE ONLY

APPROVAL

From _____ am/pm

on ___/___/___

to _____ am/pm

on ___/___/___

Weekly rate \$ _____

Other _____

Pay E/R _____ WKR _____

Auth/Chq _____

by _____ / /

Int Est \$ _____

F/u _____